GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
PITUITARY SUPPRESSIVE AGENTS, LHRH PA SUMMARY

Preferred	Non-Preferred
Eligard (leuprolide 7.5 mg [1 month], 22.5 mg [3 month], 30 mg [4 month], 45 mg [6 month] subcutaneous injection kits) Leuprolide 1 mg [daily] subcutaneous injection generic Lupron Depot (leuprolide 3.75 mg, 7.5 mg [1 month], 11.25 mg, 22.5 mg [3 month], 30 mg [4 month] intramuscular injection kits) Lupron Depot-Ped (leuprolide 7.5 mg, 11.25 mg, 15 mg [1 month] intramuscular injection kits) Oriahnn (elagolix/estradiol/norethindrone)* Orilissa (elagolix)* Synarel (nafarelin)	Fensolvi (leuprolide 45 mg [6 month] subcutaneous injection kit) Lupron Depot (leuprolide 45 mg [6 month] intramuscular injection kit) Lupron Depot-Ped (leuprolide 11.25 mg, 30 mg [3 month] intramuscular injection kits)

*preferred but requires PA

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Oriahnn and Orilissa are preferred but require prior authorization (PA).
- **The PA criteria below is for Pharmacy Services only.** Physicians administering medication in a clinic or office must bill the drug through Physician Services and not through Pharmacy Services. Information regarding the Providers' Administered Drug List (PADL) is located at www.mmis.georgia.gov and log in to request coverage from Physician Services.

PA CRITERIA:

Fensolvi and Lupron Depot-Ped 11.25 mg, 30 mg (3-month) Kits

- Medication must be administered in the member's home or in a long-term care facility.
- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Lupron Depot-Ped 7.5 mg, 11.25 mg and 15 mg (1 month) kits, are not appropriate for the member.

Lupron Depot 45 mg (6-month) Kit

- Medication must be administered in the member's home or in a long-term care facility.
- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Lupron Depot 7.5 mg (1 month), 22.5 mg (3 month) and 30 mg (4 month) kits as well as Eligard kits, are not appropriate for the member.

Oriahnn

- Approvable for members 18 years of age or older a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least one non-steroidal antiinflammatory drug (NSAID) and one oral contraceptive.

Orilissa

- ❖ Approvable for members 18 years of age or older a diagnosis of moderate to severe pain associated with endometriosis who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least one non-steroidal antiinflammatory drug (NSAID) and one oral contraceptive.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.